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THE RIGHTS OF EMPLOYEES WITH AIDS: THE CONFLICT BETWEEN THE NEED FOR ADEQUATE INSURANCE COVERAGE AND INDIVIDUAL PRIVACY IN THE WORKPLACE

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I'm going to focus my discussion on four areas. Keeping in mind the title of this conference, "Civil Rights for the Next Millennium: Evolution of Employment Discrimination Under the Americans with Disabilities Act," I will look ahead a bit.

The four areas that I will discuss are: the importance of access to health care; workers' compensation and testing and confidentiality; Human Immunodeficiency Virus ("HIV") vaccine issues related to the Americans with Disabilities Act ("ADA")[1] and the attendant insurance issues; and questions relating to the ADA attorneys' fees and alternative dispute resolution ("ADR") provisions.

Contrary to the belief of some, HIV is not that expensive a disease on a per capita basis compared to many other diseases.[2] The estimated cost per person for lifetime treatment of HIV and Acquired Immune Deficiency Syndrome ("AIDS") is about $119,000.[3]

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1 42 U.S.C. §§ 12101-213 (Supp. V 1993).

2 William A. Bradford, Jr. et al., *The AIDS Epidemic and Health Care Reform*, 27 J. MARSHALL L. REV. 279, 299 (1994). The authors explained that costs related to AIDS treatment did not exceed those attached to other serious illnesses such as liver and heart disease, but also noted that comparative studies have not been completed. *Id. Cf.* Daniel M. Fox & Emily H. Thomas, THE COST OF AIDS: EXAGGERATION, ENTITLEMENT & ECONOMICS, IN AIDS AND THE HEALTH CARE SYSTEM 198 (Lawrence O. Gostin ed., 1990) (discussing health care industry's fear of enormous costs of AIDS treatment in early 1980s); Susan Stabile, *AIDS, Insurance and the ADA*, 10 ST. JOHN'S J. LEGAL COMMENT. 533 (1995).

3 Fred J. Hellinger, *The Lifetime Cost of Treating a Person with HIV*, 270 JAMA 474, 474 (1993). The estimated lifetime cost of treatment of an AIDS patient has climbed steadily over the past five years, partially due to a longer life expectancy and the approval of new drugs. *Id.*

In contrast, the cost of treatment for many other diseases, disabilities, and chronic conditions is much higher.[4]

Moreover, a recent survey done by the Health Insurance Association of America ("HIAA") and the American Council of Life Insurance ("ACLI") has concluded that in 1993, about 1.4 % of all claims under individual and group health policies related to HIV and AIDS.[5] So, even though the number of cases is growing, HIV claims are still not that significant a burden on the health and life insurance industry.

Although the discussions about the *Carparts*[6] decision and some of the ERISA[7] questions are very important and interesting ones, parts of the topic of this Panel should not be taking place. As the millennium approaches, we are one of the few developed countries without a program of universal access to health care. This is not just a problem for people with HIV, but for people with any kind of serious illness.[8] One of the problems with the current system is that people with serious illnesses or disabilities, including HIV, may not be employed. An employment-driven healthcare is not going to cover a lot of people who could not get jobs, or who can no longer work.[9] The number of people in this country who are without health insurance is approaching the number of people with disabilities. They are not necessarily all the same people, but thirty-two to thirty-seven million people without insurance coverage is still far too many.[10]

[4] *See* Bradford, *supra* note 2, at 299-300.

[5] American Council of Life Insurance, ACLI/HIAA AIDS Related Claims Survey: Claims Paid in 1993, *in* AIDS REFERENCE GUIDE 316.

[6] Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n, 37 F.3d 12, 28 (1st Cir. 1994) (holding that defendant qualified as employer under ADA because actual employer had delegated to defendant its duty to provide insurance to its employees).

[7] The Employer Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001-146 (1994). *See generally*, Lizzette Palmer, Comment, *ERISA Preemption and Its Effects on Capping the Health Benefits of Individuals with AIDS: A Demonstration of Why the United States Health and Insurance Systems Require Substantial Reform*, 30 HOUS. L. REV. 1347, 1367-74 (1993); James R. Bruner, *AIDS and ERISA Preemption: The Double Threat*, 41 DUKE L.J. 1115, 1116 (1992).

[8] Note, *Universal Access to Health Care*, 108 HARV. L. REV. 1323, 1325 (1995). Almost 40 million Americans were uninsured in 1993. *Id.*

[9] Anna M. Rappaport, *Policy Environment for Health Benefits: Implications for Employer Plans*, 43 DEPAUL L. REV. 1107, 1107 (1994) (recognizing that gaps in health insurance coverage exist where not all employers provide coverage and uninsured individuals do not qualify for government assistance). *But see Universal Access to Health Care*, *supra* note 8, at 1325. "Although Americans rely considerably upon their employment for health insurance, employment-based coverage has decreased." *Id.*

[10] Henry J. Aaron, *Paying for Health Care*, DOMESTIC AFFAIRS, Winter 1993, at 23. *See generally*, Thomas Bodenheimer & Kevin Grumbach, *Painful vs. Painless Cost Control*, 272

In a discussion of the ADA, AIDS and insurance questions, it might be useful to look ahead to see what a person with an illness such as HIV disease needs by way of insurance coverage. First, we should look at the need for universal coverage. Second, we should examine the need for comprehensive coverage which includes in-patient and out-patient hospital care, prescription drugs, medical equipment, diagnostic and lab services, substance abuse and mental health services, home health care and long-term hospice care, which in many cases may be less expensive than hospital care. The freedom of choice to select physicians with expertise and affordable plans and co-payments with reasonable deductibles is also important.

Within these categories, it is imperative to consider the particular needs of people with disabilities, especially those with HIV. First, and I think this is very important, coverage of pre-existing conditions and portability should be a part of any plan which is adopted, so that an individual with HIV will not be precluded from coverage if he or she takes a new job.

In a case involving the Rehabilitation Act,[11] which preceded the ADA, a postal worker who was HIV-positive requested a transfer from a post office in a small town to the larger city of Los Angeles in order to secure better medical treatment.[12] The United States Court of Appeals for the Ninth Circuit held that such a transfer is a form of reasonable accommodation to be provided by the employer.[13] The Postal Service has work sites all over the country, but there may also be a person working in a town or city where he or she cannot get medical treatment who might have to relocate to a place where it is available. In those cases, if a person changes jobs and loses insurance, a ban on coverage for pre-existing conditions creates a difficult situation.

Second, insurance plans should provide adequate coverage for prescription drugs, including access to experimental therapy. Although newer classes of drugs may provide more beneifts, as the

JAMA 634, 634 (1994) (noting 1991 statistics on health care financing, including statistic that 22% of all health care expenditures were out of pocket).

[11] 29 U.S.C. § 794 (1994).

[12] Buckingham v. United States Postal Serv., 998 F.2d 735, 737 (9th Cir. 1993). Buckingham was denied a transfer to Los Angeles because he was only employed by the Postal Service for five and a half months. *Id.* Generally, employees needed a year tenure in order to request to be transferred. *Id.*

[13] *Id.* at 743.

only drugs currently used to treat HIV have a limited success rate, HIV patients need this additional protection.[14]

Third, mental health and drug treatment benefits should be included in insurance plans. These benefits were singled out in the various plans which were raised in last year's debate over national health insurance as being different from physical health benefits, but they are necessary. Mental health and drug treatment benefits are critical for the HIV community, especially with the increase in the number of HIV cases among intravenous drug users.[15]

In addition, coverage caps should not single out specific diseases such as HIV or cancer.[16] Whatever caps exist should sufficiently cover people with chronic conditions such as HIV and hemophilia.

Finally, confidentiality should be protected. This protection is important not only to people with HIV, but also to those with other conditions. Even if a person with HIV has insurance and medical care, people have been denied individual health care services.[17]

This brings us back to a different aspect of Title III of the ADA. In *Morvant*,[18] the United States District Court for the Eastern District of Louisiana granted summary judgment for the Justice Department when it charged Morvant, a dentist, with improperly denying services to a longstanding patient after the patient informed Morvant that he was HIV positive. The dentist referred the patient to another dentist claiming that the other dentist specialized in HIV positive patients.[19] In fact, the other dentist was

[14] *See* Kathryn S. Taylor, *Fighting AIDS at Home: Hospitals, Physicians Seek Community AIDS Strategies*, HOSP., Jan. 20, 1994, at 52, 52-53 (discussing shift in focus from traditional medical care for AIDS patients to services to enhance quality of life); 1995 U.S. DEP'T. OF HEALTH & HUMAN SERVICES PUB. HEALTH REP. 110, 226 (citing $15 million study launched to improve HIV-AIDS care).

[15] *See* Center for Disease Control and Prevention, U.S. Dep't of Health and Human Services, *HIV/AIDS Surveillance Report* (1994).

[16] *See* EEOC INTERIM ENFORCEMENT GUIDELINES IN THE APPLICATION OF THE ADA TC DISABILITY-BASED DISTINCTIONS IN EMPLOYER-PROVIDED HEALTH INSURANCE (1993); *see also* Carparts Distrib. Ctr., Inc. v. Automotive Wholesaler's Ass'n, 37 F.3d 12, 28 (1st Cir. 1994); EEOC v. Gager, No. 94-CV-72089-DT (E.D. Mich. Consent Decree May 27, 1994).

[17] *See* Bradford, *supra* note 2, at 291 (citing MICHAEL T. ISBELL, HEALTH CARE REFORM LESSONS FROM THE HIV EPIDEMIC, 141 (1993)).

[18] United States v. Morvant, 898 F. Sup.. 1157, 1159 (E.D. La. 1995) (stating that failure to render dental services to known HIV-positive patient was clear violation of statute which dentist did not rebut with sufficient evidence).

[19] *Id.* at *7. The Court stated that:

> [R]eferral because of the need for 'special' infection control precautions of persons with HIV or AIDS is not appropriate. If dentists . . . follow universal precautions in their

not anymore of a specialist than Morvant.[20] The *Morvant* court based its conclusion on the equal access to goods and services provision under Title III of the ADA.[21] The remedies in *Morvant* were also instructive: monetary damages, training about HIV for the staff, and the posting of a sign in the office that services are provided to HIV positive patients.

There are other areas involving AIDS and insurance which, as the millennium approaches, are going to become more important. One issue is whether workers' compensation should be the exclusive claim available to an employee. In those states where workers' compensation is an exclusive remedy, should workers' compensation be the exclusive remedy for those people who occupationally contract HIV on the job?[22] This is particularly pertinent to doctors and other health care professionals.

Consider when a person seeks treatment for a work-related injury, such as a back problem, and tells the nurse to be careful administering treatment to him because he is HIV positive. The nurse then tells others, including the physician, and the information eventually becomes part of the individual's medical record. It then becomes part of his insurance record when it is reported to the Medical Information Bureau. Is that considered a breach of confidentiality? It is only tangentially related to workers' compensation, but it is still related. The California court of appeals held that such disclosure was inappropriate.[23]

A different kind of issue has come up in at least two cases.[24] Strangely, both cases involved people who work in tire shops re-

practice, persons with HIV or AIDS or other blood-borne pathogens can be safely treated in the dental setting.

Id.

[20] *Id.*

[21] *Id.* at *10.

[22] *See, e.g.*, Blythe v. Radiometer Am., Inc., 866 P.2d 218, 220 (Mont. 1993) (establishing workers' compensation as exclusive remedy for exposure to AIDS virus in workplace); Vallery v. Southern Baptist Hosp., 630 So. 2d 861, 863 (La. Ct. App. 1993) (preventing recovery for exposure to AIDS in workplace in excess of workers' compensation).

[23] Urbaniak v. Newton, 277 Cal. Rptr.3d 354, 357 (Cal. Ct. App. 1991). Medical assistants are required to keep HIV-positive status of patients confidential where such information was provided by patient for sole purpose of taking safety precautions and not connected to medical treatment sought. *Id.* The Court reasoned that Urbaniak "reasonably anticipated privacy" when he disclosed his HIV-positive status to the nurse. *Id.* at 361. Thus, the court chose to recognize such expectation to further the public interest of encouraging confidential communications in this area. *Id.*

[24] *See, e.g.*, Sacramona v. Bridgestone/Firestone, Inc., 152 F.R.D. 428, 428 (D. Mass. 1993) (seeking to force high-risk plaintiff to submit to HIV blood test in order to show decreased life expectancy in computing damages for future earnings); Pettyjohn v. Goodyear

mounting tires. Where you have a work-related injury, and an individual claims it as part of his workers' compensation benefits, he should be entitled to damages for loss of future earnings, diminution of future earning capacity, future medical costs, and future disability costs. But is it appropriate to ask that individual to undergo an HIV test? An HIV test, if positive, will be a determinant of that individual's life span, and could influence the appropriateness of an award for future damages.

In *Pettyjohn v. Goodyear Tire & Rubber Co.*, the United States District Court for the Eastern District of Pennsylvania concluded that a defendant has a compelling need to know about the plaintiff's HIV-status because it is the plaintiff who brought the issue of future damages into question.[25] In Massachusetts, the United States District Court for the Eastern District of Massachusetts found that the plaintiff's HIV-status was not a relevant consideration and did not require the plaintiff to be tested.[26] In that case, the court decided that the defendant could not cause information to be created so that it then could be discovered.[27]

Preventive vaccines present the problem of the possibility of a false-positive result to an HIV-test. Though these vaccines are not in expanded efficiency or Phase Three trials yet, they are in use in clinical trials. Over 1600 people have been tested and are undergoing part of safety and immunogenicity or Phase One and Phase Two trials. A person participating in a clinical who takes a vaccine in order to develop the desired immune response may show positive antibodies on an Elisa or a Western Blot Test. This false-positive result is an effect of the vaccine, not the presence of the virus.[28]

Tire & Rubber Co., No.91-CV-2681, 1992 WL 105162, at *1 (E.D. Pa. 1992) (seeking damages for future earnings due to personal injuries caused by explosion on job).

[25] *Pettyjohn*, 1992 WL 105162, at *1.

[26] *Sacramona*, 152 F.R.D. at 431-32 (reasoning that HIV status is in issue where it is sought to prove liability but not for future damages).

[27] *Id.*

[28] *See* Robert E. Stein, *Vaccine Liability and Participant Compensation Incentives in HIV Vaccine Trials*, *in* AIDS RESEARCH AND HUMAN RETROVIRUSES 5257 (Supp. 2 1994); Robert E. Stein, *Insurance and Liability Issues in the Development of an HIV Vaccine*, 10 FOOD DRUG COSM. & MED. DEVICE L. DIG. 80, 80 (1993); *see also HIV Vaccinations to be Evaluated in Field Trials*, HOSP., June 5, 1994, at 26 (reporting contract in support of field trials to test effectiveness of vaccines "to develop a safe and cost-effective vaccine for the prevention of HIV infection").

In the current environment, a false-positive result may cause such person to suffer a range of social harms,[29] including, but not limited to, job termination, travel restrictions, blood donation restrictions and difficulty in obtaining health and life insurance because of that HIV test—a test that reflected an antibody status due to a vaccine and not the virus. This fact places an obligation on the administrators of the vaccine trials to provide appropriate counseling to and secure informed consent from volunteers. It also necessitates a careful understanding by insurance companies of the issues involved. For example, since 1990, the National Institutes of Health ("NIH"), which sponsors HIV vaccine trials, has sent letters to insurance company associations to alert them to the possibility that an individual taking a vaccine may have positive antibodies under a normal reading of an Elisa or Western Blot test.

Currently, it is possible to distinguish between vaccine induced antibodies and viral-induced antibodies on a Western Blot reading. That may become more complicated, but there are tests which will distinguish viral antibodies from vaccines.

How does this relate to the ADA? The statute protects a person with a physical or mental impairment, or who is regarded as having an impairment.[30] Thus, a person with a test indicating positive antibodies due to a vaccine may be reported to state authorities, pursuant to mandatory state reporting laws. That report constitutes a record.

This situation has come up a number of times. Volunteers in NIH trials are given tamper-proof cards which provides a toll- free telephone number of the vaccine evaluation unit where the trial is being conducted. This way an individual, at the same time as the clinical trial center, provides an employer or insurer with more information about the kind of vaccine being used in order to determine whether a positive result is due to the vaccine or an infection.

[29] *See* 1988 U.S. DEP'T. OF HEALTH & HUMAN SERV. PUB. HEALTH REP. 103, at 52-57.

[30] 42 U.S.C. § 12102(2) (Supp. V 1993). Section 12102(2) provides:

> The term 'disability' means, with respect to an individual . . . (A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual; or (B) a record of such impairment: or (C) being regarded as having such an impairment.

Id.

A card, however, does not and should not indicate that because a person is participating in a trial, he or she is not HIV-positive due to infection with the virus. Because we do not know yet what the efficacy of the vaccine is going to be, it may be that an individual will take a vaccine in a clinical trial, and despite counseling, engage in unsafe activities and contract the virus. This will be a more prominent issue as vaccine trials increase.

As the millennium approaches, and we consider ways in which the ADA can effectively handle some of the smaller problems which lawyers may not want to take because there may not be a large contingency fee involved, there are two sections of the ADA that have not, but really should be, considered together.

One is the ADR section which encourages the use of alternative dispute resolution,[31] and the other is the attorneys' fee provision,[32] which can provide fees to the prevailing party. Unless attorney fees can be provided to the prevailing party using an ADR mechanism, few lawyers will take advantage of those approaches. Instead, they will pursue litigation where they have the possibility of getting attorney's fees, although litigation may take longer and be far more expensive.

Consider the *McGann*[33] and *Carparts*[34] cases. In both of these cases, the plaintiff is the estate of the person who originally brought the action. Litigation can take a very long time. Therefore, it may be advantageous to consider using ADR mechanisms including mediation and arbitration. Unless the issues of ADR and attorneys' fees are considered together, ADR will remain underutilized.

An historian, William McNeil, concluded in his book, *Plagues and Peoples*, which reflected upon the historical relationship be-

[31] 42 U.S.C. § 12212 (Supp. V 1993). Section 12212 provides:
[W]here appropriate and to the extent authorized by law, the use of alternative means of dispute resolution, including settlement negotiations, conciliation, facilitation, mediation, fact-finding, minitrials, and arbitration, is encouraged to resolve disputes arising under this Act.
Id.

[32] 42 U.S.C. § 12205 (1994). Section 12205 provides:
In any action or administrative proceeding commenced pursuant to this Act, the court or agency, in its discretion, may allow the prevailing party, other than the United States, a reasonable attorney's fee, including litigation expenses, and costs, and the United States shall be liable for the foregoing the same as a private individual.
Id.

[33] McGann v. H & H Music Co., 946 F. Supp. 401, 403 (5th Cir. 1991).

[34] Carparts Distribution Ctr., Inc. v. Automotive Wholesaler's Ass'n, 37 F.3d 12, 28 (1st Cir. 1994).

tween a disease and society in history, that "infectious disease which antedated the emergence of humankind will last as long as humanity itself, will surely remain, as it has been hitherto, one of the fundamental parameters in determinance of human history."[35] Certainly HIV and the ADA and insurance fit within that kind of conundrum.

[35] WILLIAM H. MCNEILL, PLAGUES AND PEOPLE 257 (1976).